2025 Stateline Family YMCA Summer Camp
Little Adventure Camp Registration
Contact: Carley (cbarger@statelineymca.org)

Camper Information:

Last Name _____ First Name _____ MI _____
Nickname _____ Gender [ ] Male [ ] Female [ ] Other _____
DOB _____ Age When Camp Begins ___ Primary Phone # _____
Address _____ City _____ State ___ Zip Code _____
School Attending _____ Grade Fall 2025 _____

(1) Parent/Guardian Information:

Last Name _____ First Name _____ MI _____
DOB _____ Gender [ ] Male [ ] Female [ ] Other _____
Phone #'s: Cell _____ Work _____ Employer _____
Address _____ City _____ State ___ Zip Code _____
Email Address _____

(2) Parent.Guardian Information:

Last Name _____ First Name _____ MI _____
DOB _____ Gender [ ] Male [ ] Female [ ] Other _____
Phone #'s: Cell _____ Work _____ Employer _____
Address _____ City _____ State ___ Zip Code _____
Email Address _____

Medical and Behavior Questions: (these help us provide the best care possible)

Has your child been diagnosed or treated for the following?

[ ] Asthma [ ] Allergies [ ]Allergy to Insect Stings
[ ] Diabetes [ ] Dietary Needs [ ]Other _____
[ ] ADD/ADHD [ ] Seizures

Physician's Name _____
Physician's Phone _____
Preferred Hospital _____

Additional Info:
(Specific Allergies/Dietary Needs)
_____
_____
_____
_____

Parent's Statement of Understanding

I understand that my child must be physically signed in/out by authorized adults	[ ] Yes [ ] No
I understand that the YMCA is not responsible for lost, stolen, or damaged personal articles	[ ] Yes [ ] No
I understand that my weekly balance is due by the Monday prior to the week attending	[ ] Yes [ ] No
I understand that my child must be able to use the bathroom on their own	[ ] Yes [ ] No
I understand the deposit, balance due, and refund policies located in camp guide	[ ] Yes [ ] No
I give permission to the Stateline Family YMCA to:	
Seek medical treatment for my child, in my absence, in the event of an emergency	[ ] Yes [ ] No
Use photos or videos taken of my child for any and all promotional purposes	[ ] Yes [ ] No
To transport my child as necessary for all activities: Bussing, Swimming, Field Trips	[ ] Yes [ ] No
Allow my child to go on short walks with the group leader under Y staff supervision	[ ] Yes [ ] No
Allow my child to participate in field trips	[ ] Yes [ ] No
To apply sunscreen/bug repellent that I supplied to my child	[ ] Yes [ ] No

Parent/Guardian Signature _____ Date _____

For Office Use: Carley

Additional Camper Information

Camper's Name _____ DOB _____

Social and Emotional Needs

Fears or Phobias (e.g, spiders, heights, darkness):	Behavioral Triggers (situations, sounds, environments):	Coping Strategies (techniques to calm down):	Social Skills (e.g., shy, outgoing):
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Developmental Considerations

Developmental Delays (any known concerns):	Special Interests or Hobbies:
_____	_____
_____	_____
_____	_____
_____	_____

Behavioral Information

Previous Camp Experience:

_____

_____

Behavioral Concerns (specific behaviors to monitor):

_____

_____

Reward Systems (ways to encourage positive behavior):

_____

_____

Parental Insights

Parent Concerns (any specific concerns regarding camp experience):	Preferred Communication (best way to communicate w/ you):	Cultural or Family Traditions (any relevant practices):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Notes

Anything Else (additional information to help camp staff):

_____

_____

_____

_____

Thank you for completing this section! The information is important to help us provide the best care possible We look forward to a fun and enriching camp experience for your child!

For Office Use: Carley

Camper Info:

Last Name _____ First Name _____ MI _____
DOB _____ Primary Phone # _____ Gender [ ] Male [ ] Female [ ] Other
Address _____ City _____ State ___ Zip Code _____

Camp Registration:

Camp Fees

	Y Members	Non Members	Deposit Due at Time of Registration
Weekly (M-F)	$235	$315	$25

Camp T-Shirt $10
[ ] YXS [ ] YS [ ] YM [ ] YL

Camp Enrollment

WK	DATE	THEME	Select Weekly
1	June 2-6	Anchors Away	[ ]
2	June 9-13	Coral Cove Cruise	[ ]
3	June 16-20	Enchanted Forest	[ ]
4	June 23-27	Buggin' Out for Nature	[ ]
5	June 30-July 3	Creative Cadence	[ ]
6	July 7-11	Red, White and YOU	[ ]
7	July 14-18	Spectacle of Sports	[ ]
8	July 21-25	Hello Hollywood	[ ]
9	July 28- Aug 1	Dancing Decades	[ ]
10	Aug 4-8	In My Kind Kid Era	[ ]
11	Aug 11- 15	Game Show Mania	[ ]
12	Aug 18-22	Surfin' Safari	[ ]
NON REFUNDABLE/NON TRANSFERABLE DEPOSIT DUE AT TIME OF REGISTRATION			$25/Week $_____

All remaining balances are due in full the Monday prior to the week your child will be attending.

Payment Plans

- Includes ALL 12 weeks of camp
- $10 Discount on Youth Summer Swim Lessons (must register in-house)
- Camp T-Shirt – receive on 1st day of camp

[ ] Option 1 Pay In Full	[ ] Option 2 5 Month Draft	[ ] Option 3 4 Month Draft
- $2115 - Lock-In by May 5th - Due at time of registration	- $2160 - Lock-In by March 5th - $432 Draft on the 5th of each month, March-July	- $2160 - Lock-In by April 5th - $540 Draft on the 5th of each month, April-July
SAVINGS UP TO $1,685	**SAVINGS UP TO $1,640**	**SAVINGS UP TO $1,640**
Payment Plans are NON-REFUNDABLE/NON-TRANSFERABLE - No Exception Granted.		

For Office Use: Ruthie

2025 Stateline Family YMCA Summer Camp
Little Adventure Camp Payment Information Form

Parent/Guardian Information:

Last Name _____ First Name _____ MI ____ DOB _____

Address _____ City _____ State ____ Zip Code _____

Camper's Name _____ DOB _____

Total # of Weekly Registrations	____	x $25	=	$
Total # of Camp T-Shirts	____	x $10	=	$
Grand Total Due At Time of Registration				**$**

OFFICE USE ONLY

YES
[ ] Daxko registration matches form
[ ] 2nd Child discount applied if applicable
[ ] Bank draft scheduled by Childcare Billing Specialist

_____
Signature Date
(Childcare Billing Specialist)

Select Payment Option for Remaining Balance:

Remaining Balance Due (Fee less the deposit)

[ ] Weekly Draft — Will draft the Monday prior to the week registered
[ ] Payment Plan- Option 1 — Will be paid at time of registration
[ ] Payment Plan- Option 2 — Will draft on the 5th of e/ month March- July
[ ] Payment Plan- Option 3 — Will draft on the 5th of e/ month April- July

Camper's Name _____

[ ] Checking Account
Bank Name _____
Account # _____ Routing # _____

[ ] Savings Account
Bank Name _____
Account # _____ Routing # _____

[ ] Credit Card
Name on Card _____
Account # _____ Card Type _____
(Discover, Master Card, Visa)
Expiration Date _____ CID # _____

- This authorization continues indefinitely and automatically until cancelled by the person signing this authorization. Draft cancellations require a 15 day notice.
- Amount of draft will be determined by the elected program, the fee and adjustments defined by the program policy. The fee may be adjusted based on increased fee rates or adjustments as defined by the program policy.
- Each program requires separate authorization forms.
- All drafts are non-refundable.
- A fee of $25 will be charged for all returned drafts. Two charges of this type may result in expulsion from the program.

I authorize the Stateline Family YMCA to the above named bank or credit card account for membership or program fees. Any change in fees may constitute a change in the draft amount. I understand that the Stateline Family YMCA may initiate a pre-authorization to validate the account number listed. I also understand that I am liable for the entire balance plus the processing fee for returned drafts.

_____ _____
Authorized Signature Date

For Office Use: Ruthie

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child.		
☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition

☐ Asthma ☐ Diabetes ☐ Gastrointestinal or feeding concerns including special diet and supplements

☐ Cerebral palsy / motor disorder ☐ Epilepsy / seizure disorder ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

For Office Use: Carley

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

For Office Use: Carley

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/2017)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1 PERSONAL DATA PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (**X**) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

STEP 3 REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1] If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2] If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3] MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4] Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 SIGNATURE

To the best of my knowledge, this form is complete and accurate.

_____ _____

SIGNATURE - Parent, Guardian or Legal Custodian Date Signed

For Office Use: Carley

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

For Office Use: Carley

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

http://dcf.wisconsin.gov

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off**.** If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

For Office Use: Carley